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Title

Equity: a common goal for primary care.

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Equity: a <u>common goal</u> for primary care.

> *"Medical services are not the main determinant of mortality or morbidity … But that is no excuse for failure to match the greatest need with the highest standard of care".* Julian Tudor-Hart (1)

When the Covid-19 pandemic begins to fade will our collective recognition of the increasing inequalities in UK societies also fade away? The milestones of the 2020 pandemic unfolded worldwide along societal fault lines of inequities in wealth and power, which result in inequities in health and basic social protection.(2) The surge of media interest in the social determinants of health, whether of poverty, racism or insecure employment brought to the fore the well documented lived experiences of patients. The mental and physical consequences are witnessed daily by GPs, who share the common purpose of equitable service provision.(3)

Increasing inequalities

Increasing social and health inequalities have become the hallmark of recent decades, punctuated by multiple reports and by multiple missed opportunities for redress.(4, 5) Most recently Marmot in 2010 and 2020 (6, 7) has documented the curtailment of earlier reductions in mortality and gains in health. Male mortality in middle age has increased for the first time in peace-time, echoing the earlier American experience of *'deaths of despair'* from alcohol, drugs and suicide.(8) For black and south Asian ethnic groups in middle life, inequalities in health-related quality of life are even more pronounced, and disproportionately affect women.(9)

This gives added weight to the observation that health inequalities do not automatically improve with national prosperity. The social determinants of much health inequality are the products of national government policy and funding choices. With 50% of children in deprived areas living in poverty, the effects of years of austerity will extend far into their futures.(7) Child obesity, foodbanks and homelessness are the daily visible consequences of public policy.

Challenges for Primary Care

For GPs individual relationships with patients are central, and there is a temptation to re-formulate the relational concept of health inequalities as simply the sum of lifestyle and other choices made by patients: a set of individual personal choices which can be made well or less well. But this formulation risks casting a long shadow over the individual, casting them as both perpetrator and victim, and provides neither societal context nor agency.

These are not straightforward waters for GPs to navigate, and the uneasy fit between supporting an individual to make life changes and the unyielding context of deprivation can lead to what Mackenzie and others have called a *'fantasy paradigm',* described in relation to the national policy to roll-out social prescribing programmes in primary care as a solution to health inequalities.(10) *'Fantastical'* as they are largely disconnected from the socio-political context of health, instead operating through the belief that population level inequalities can be eradicated at the level of individuals.

This is not to imply that social prescribing is of little value. On the contrary it enlarges and de-medicalises the range of therapies available to practitioners, builds links with community providers and may support social cohesion. But even among well-established programmes only a minority of people engage, and for many the work of lifestyle change is distressingly far from their immediate concerns. Moreover, these programmes are often complex to implement and evidence of improvement in either health-related quality of life or mood disorders remains to be established.(11)

Macro-economic changes in resource allocation and the will to implement social policies proportionate to population need are required to reduce the increasing slope of health inequalities.(6) Universal primary care is an essential tool in the mitigation of these inequalities, but is hampered by the continuing effects of the inverse care law on the delivery of proportionate services. The UK GP resource allocation formula continues to discriminate against disadvantaged areas, as those in Deep End practices and inner urban areas can testify(12), while Babylon's marketisation of low risk populations is a major threat to proportionate funding. The clinical effects of the inverse care law are in plain sight: hypertension still remains uncontrolled in almost half of cases,(13) and high intensity statins are prescribed to only half of those with established CVD. These well-established facts are made clearer by the march of the pandemic. While it is social conditions which determine the unequal rates of Covid infection, these effects can be substantially mitigated by equity of Covid immunisation delivered by local services cognisant of their population needs.

Next steps

In east London the Clinical Effectiveness Group (CEG) https://www.qmul.ac.uk/blizard/ceg has worked collaboratively with all local practices for more than twenty years to support the common purpose of health improvement for all. This consists of a data enabled approach to the identification of health inequalities and practical support for opportunities to improve practice. By implementing quality improvement programmes engaging primary and secondary care clinicians and CCGs, CEG has encouraged the growth of practice networks which share both data and innovation. The clinical impact, including some mitigation of health inequalities, is considerable. These inner east London CCGs - which fall in the top decile of deprivation - have achieved the best performance in England for blood pressure management and the use of statins in cardiovascular disease.(14)

CEG introduced the first comprehensive approach to recording self-reported ethnicity to track equity, (15) this is now included in the 2021 GP contract. With over 95% ethnicity recording among adults in east London we can show the absence of ethnic inequalities in the management of chronic kidney disease, in contrast to findings elsewhere.(16) Effective learning health systems such as this rely on innovative uses of electronic health records to support clinical decision making and illuminate inequalities. As witnesses to the lives of the populations we serve as GPs, these tools can help to mitigate inequalities and support advocacy for change.

To deliver this unconditional, proportionate care GPs require time, empathy and a person-centred approach to lives that may be complex and often under severe stress. Tudor-Hart

argued that the NHS is not a business designed to make money, but a social institution based on mutuality and trust, where people are able to get what they need as well as giving what they can.

For him ...*" the most satisfying and exciting things have been the events that have not happened: no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care."(17)*

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